Appendix D

The Crisis in Colorado Children's Healthcare – An Opportunity to Improve!

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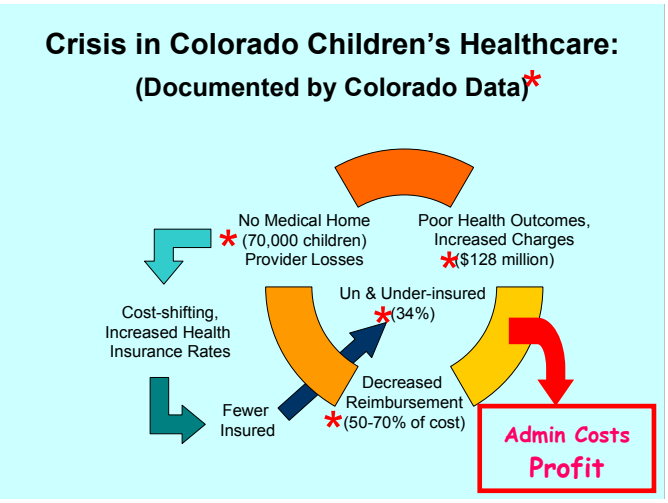
There has been a gradual decrease in the proportion of children covered by private health insurance in Colorado with a commensurate increase in those with public insurance (20%) or having no insurance (14%).[1] Compounded by limitations in FQHC location and capacity, Medicaid/SCHIP under-payment for physician services and adverse administrative policies in Colorado have decreased the willingness of physicians in private practice to accept new patients with public insurance.[2] To complicate matters, Colorado Access, the only front-range managed care Medicaid option and the most successful in attracting physician participation, has dropped out of the program citing decreasing capitation rates that don't cover costs. This will increase the trend forcing children into the Unassigned-fee-for-service (UFFS) Medicaid option – a category known to have a poor primary care provision record. These public policies result in decreased access to primary care (affecting an estimated 70,000 children in the Denver metropolitan area and 140,000 children state-wide), fewer primary care visits, poor vaccination rates and financially compromised healthcare providers.[2]

There are measurable consequences of such policies including: poorer health outcomes, increased emergency room usage, increased hospitalization rates, and increased hospitalization costs (especially in the UFFS category).[3] Compared to those with private insurance, children in Colorado with public or no insurance have significantly higher rates of total hospital admission as well as admission for: chronic illness, asthma, diabetes, vaccine-preventable disease, psychiatric disease, and ruptured appendix. These children have higher death rates, higher severity of illness, are more likely to be admitted through the emergency department, and have significantly higher (but often under-compensated) hospital charges. If children with public or no health insurance in Colorado had the same outcomes as children with private insurance, an estimated $128 million and a additional amount in emergency department charges might have been saved in 2005. Under the current policies, physician and hospital losses incurred in caring for publicly insured children ultimately result in cost-shifting to the Colorado private sector (see figure).[4, 5]



[1] *"Approximately 32 percent of our poorest children have no health insurance. Children may be eligible for public health insurance programs in Colorado such as Medicaid or Child Health Plan Plus if their family's income is at or below 185 percent of the Federal Poverty Level. Barriers to enrollment in these programs include: a complex eligibility determination processes; a lack of public awareness of program availability; unstable state and federal funding; strict income thresholds (among the strictest in the nation); and restrictive eligibility requirements, such as the Medicaid Asset test, which precludes families with assets of more than $1500 from being eligible for Medicaid."* Colorado Children's Campaign, Kids Count in Colorado, 2005.http://www.coloradokids.org/includes/downloads/kc2005book.pdf

[2] Medicaid-participation surveys of Colorado pediatricians conducted in 2000 and 2003 documented a significant decrease from 41.4% in 2000 to 23.9% in 2003 in the percentage of pediatricians who accepted all Medicaid patients. The most influential reason cited for this decreased participation was low reimbursement that failed to cover overhead costs. According to the 2003 survey results, 83% (up from 57% in 2000) of respondents believed that low Medicaid payments failed to cover the overhead costs of visits. At the same time HEDIS surveys from 1999-2005 show consistently poor vaccination and primary care visit rates for Colorado Medicaid children especially in the UFFS group. Stephen Berman, MD; Carl Armon, MSPH; and James Todd, MD. Impact of a Decline in Colorado Medicaid Managed Care Enrollment on Access and Quality of Preventive Primary Care Services. Pediatrics 2005; 116:1474–1479

[3] James Todd, Carl Armon, Anne Griggs, Steven Poole, Stephen Berman. Increased Rates of Morbidity, Mortality, and Charges for Hospitalized Children with Public or No Health Insurance as Compared to Children with Private Insurance in Colorado and the United States. Pediatrics 2006; 118(2): 577-85

The Colorado Student Assessment Program (CSAP) was designed by the State of Colorado *"to provide a picture of how students in the State of Colorado are progressing toward meeting academic standards, and how schools are doing to ensure learning success of students."*[6] Using CSAP as a model, the precedent of measuring outcomes can be replicated to improve our children's healthcare outcomes and costs. Given consistent access to and critical analysis of existing State healthcare data we have the ability to better measure both the costs and outcomes of our healthcare policies, and the opportunity to work collaboratively with clinicians, legislators, the administration, and the business community to improve morbidity and mortality as well as decrease hospitalization costs for all Colorado children (see table below). Successful "medical home" models for providing such care and achieving such savings have been demonstrated in Grand Junction and Denver (the Colorado Children's Healthcare Access Program (CCHAP))[7], and other parts of the country.[3]

Allocating the dollars associated with excess hospital utilization and emergency department usage by children with public or no health insurance (estimated to be well over $100 million in charges for Colorado in 2005) to improve access to and efficacy of primary care for these same children provides a significant financial incentive for making quality health care for all Colorado children the priority it should be.

Key Principles for an Effective Medical Home System for Colorado's Children

- **Commitment to assure quality healthcare via a medical home for all Colorado's children.**
- **Collaborative effort of clinical, public, and private sectors.**
- **Meaningful clinical /medical direction and oversight for HCPF.**
- **Ongoing access to and analysis of relevant State healthcare data (Healthcare "CSAP") with a focus on measurable outcomes and risk groups as well as costs.**
- **Adequate reimbursement (not-for-loss) and system efficiency to assure access.**
- **Measurable medical home standards for provider participation.**
- **Standards and incentives for meaningful personal/parental role in preventive care and responsible health resource use.**

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[4] "In recent years, business groups have become increasingly interested in how the Medicaid program operates because payments made to doctors and hospitals that treat the Medicaid population has a direct bearing on private insurance rates. When the state underpays for Medicaid, for example, the costs are shifted to paying patients, most often people with employer-paid health insurance." The Denver Business Journal - August 10, 2004

[5] *Research shows managed care works* by Amy Fletcher. The Denver Business Journal - August 7, 2006

[6] Colorado Revised Statute (C.R.S.) 22-7-102. Legislative Declaration (Educational Accountability) Declares that the purpose of (Educational Reform related to Standards and Assessments) in Colorado is to institute an accountability system to define and measure academic quality in education and thus to help public schools of Colorado to achieve such quality and to expand the life opportunities and options of the students of this state. It is the belief of the general assembly that developing the evaluation mechanisms will provide for: means for determining whether decisions affecting the educational process are advancing or impeding student achievement, means for reporting to students, parents and the general public on the educational performance of the public schools, and the collection and provision of performance information that could help school districts to increase their efficiency in using available financial resources. http://www.cde.state.co.us/cdeassess/co_law.html

[7] Steven Poole, MD (Department of Epidemiology and Community Pediatrics, TCH); Roger Shenkel, MD; David Herr, MD (Rocky Mountain Health Plan). Ongoing Studies, 2006